



FLEXIBLE BENEFITS PLAN

ELECTION FORM

Effective JANUARY 1, 2013 through DECEMBER 31, 2013

PLAN INFORMATION

EMPLOYER NAME: WASHINGTON COUNTY

PLAN YEAR: 2013

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME			DATE OF HIRE	SOCIAL SECURITY NUMBER	
LAST	FIRST	MI			
HOME ADDRESS					
NUMBER AND STREET		CITY	STATE	ZIP CODE	
DATE OF BIRTH	E-MAIL ADDRESS		PHONE NUMBER	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
PARTICIPANT'S EFFECTIVE PLAN DATE _____			DATE OF FIRST PAYROLL DEDUCTION _____		

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase one or more of the following benefits. I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.

BENEFIT ELECTIONS OPTIONS	ELECTION	DEDUCTION		
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) You can elect a maximum of \$ 2500.00 per plan year.	Yes No <input type="checkbox"/> <input type="checkbox"/>	\$ _____ PER PAY PERIOD	No. of Paychecks	\$ _____ ANNUAL
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCA) NOTE: DCA IS FOR CHILDCARE SERVICES ONLY Maximum of \$5,000 per Plan Year if single parent or is married and filing a joint return. Maximum of \$2,500 if married and filing separately.	Yes No <input type="checkbox"/> <input type="checkbox"/>	\$ _____ PER PAY PERIOD	No. of Paychecks	\$ _____ ANNUAL

I have reviewed and understand the terms and conditions of this plan. I understand that I can not change or revoke this election at any time during the Plan Year unless I have a Qualifying Life Event change (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses and must submit such receipts to my plan administrator for claims substantiation.

☐ YES, the benefits of the Plan have been explained to me and I elect to participate as indicated above.

OPTIONAL:

☐ I would like to request an additional card for my spouse or tax dependent, please send an additional card request form to my home address.

PARTICIPANT'S SIGNATURE X	DATE
HR'S SIGNATURE X	DATE

Tall Tree Administrators. 802 E Winchester Rd, #250. Salt Lake City, UT 84107. 877.453-4201. 801.274.8900. mvzomeren@talltreehealth.com

www.benefitspaymentsystem.com